Nurse and Midwife Medicinal Product Prescribing
Site Declaration Form

This *Site Declaration Form* is to be completed by the Director of Nursing/Midwifery and submitted with the application to the higher education institution (HEI).

Candidate's Name:_____ **NMBI PIN:** _____

Criteria	Yes	No	Comment/Evidence
Safe Management			
Do you have in place an *Organisational Policy for Nurse and Midwife Medicinal Product Prescribing* (The *National Policy for Nurse and Midwife Medicinal Product Prescribing* can be adapted for local use)?			
Do you have risk management systems in place?			
If yes, is there a process for:			
• Adverse event reporting?			
• Incident reporting?			
• Reporting of near misses?			
• Reporting of medication errors?			
Practice and Education Development			
Do you have in place robust and agreed collaborative practice arrangements with the multidisciplinary team?			
Have you identified named /mentor (medical practitioner) who has agreed to support the candidate through the education programme and the development of the Collaborative Practice Agreement (CPA)?			
Can you confirm that the name of the nurse or midwife applying for the education programme, is on the Active Register maintained by the Nursing and Midwifery Board of Ireland i.e. has current active registration?			
Health Service Provider			
Do you have in place or have access to a *Drugs and Therapeutics (D&T) Committee* or a review group for the purpose of nurse and midwife medicinal product prescribing? (If No, please describe how this will be achieved?).			
Do you have in place local governance arrangements to oversee the introduction and implementation of nurse and midwife medicinal product prescribing?			
Do you have in place a named Prescribing Site Coordinator (PSC) delegated by the Director of Nursing/Midwifery to have responsibility for the initiative locally and for liaising with the HEI? For candidates employed in the voluntary and statutory services of the HSE the Prescribing Site Coordinator will also liaise with members of the HSE prescribing team. Please supply name and contact details of PSC.			**Name:**_____ **Email:**_____ **Telephone:**_____
Have you established the clinical indemnity arrangements for nurse and midwife medicinal product prescribing? (Please note the Clinical Indemnity Scheme managed by the State Claims Agency indemnifies employees of the voluntary and statutory services of the HSE).			
Do you have in place a firm commitment by the health service provider's senior management to support the introduction of nurse and midwife prescribing?			
For HSE statutory and voluntary services will you have in place a signed sponsorship agreement at local (service) level setting out the arrangements for study leave and financial support for the candidate, as outlined on page 4?			
Do you agree to support the following mandatory requirements: ▪ Support the candidate to develop Draft CPA as a requirement of CPA assignment for the education programme. ▪ Submission by candidate of list of medicinal products of CPA to D&T			

committee/Review Group for review within **3 months of successful completion of the education programme.** ▪ Once CPA approved and signed by DON/M, commitment by candidate to submit documents for registration to the Nursing and Midwifery Board of Ireland within **two weeks**.			
For candidates employed in the HSE voluntary and statutory services (only) can you confirm that the Registered Nurse Prescriber will have access to a computer, email and internet for data input to the *Nurse and Midwife Prescribing Data Collection System* where required and agreed locally?			
Audit and Evaluation			
Do you have in place or are you planning to put in place an agreed schedule for routine audit of nurse and midwife medicinal product prescribing? The *Nurse and Midwife Prescribing Data Collection System* is available for local use as a support for monitoring and clinical audit.			

Printed name of the Director of Nursing/Midwifery or relevant Nurse/Midwife Manager:		**Printed name** of the Medical Practitioner/Mentor	
Name of health service provider:		Name of health service provider:	
Telephone number:		Telephone number:	
Email:		Email:	
Signature:		Signature:	
Date:		Date:	

Please check the following:

1. The form is fully completed. Incomplete forms will not be considered.

2. The mentor is aware of their mentorship requirements. The mentor can contact the relevant HEI programme co-ordinator or a member of the HSE prescribing team for further information prior to signing the form.

3. The name of the candidate given on the application form is the name by which they are registered with the NMBI and which will appear on their student ID card, college records and parchment.

The completed form should be returned to the relevant HEI by the closing date for receipt of student application form.

DECLARATION OF CONSENT

For candidates employed in the HSE voluntary and statutory services (only):

The HSE ONMSD funds each candidate. Candidates are therefore required to give consent for relevant information regarding status on the education programme to be shared by HEI with the HSE ONMSD for tracking and monitoring purposes only.

PART 1:

I _____ hereby give permission to (please fill in the name of the College) _____to provide information listed below to the Office of the Nursing and Midwifery Services Director, Health Services Executive, for the purpose of completing a data base of the nurses and midwives undertaking a nurse/midwife prescribing programme. I understand that the information provided by the University will be used solely for the purpose stated.

HSE Area
HEI
Cohort (e.g. January 2017)
Student First Name
Student Surname
NMBI PIN
Grade (e.g. Staff Nurse/CNM 2)
Clinical area to which assigned
Phone Number
Email Address (work if possible)
Hospital Name
Director of Nursing/Midwifery
Prescribing Site Coordinator (PSC) name, e-mail address and telephone umber

Student name _____

Student signature_____

Date_____

Part 2

I _____ hereby give permission (please fill in the name of the College) _____to inform the Office of the Nursing and Midwifery Services Director, Health Services Executive, as to my status on the programme. I understand that the information provided by the University will be used solely for the purpose stated.

Student name _____

Student signature_____

Date_____

Appendix 1

Declaration /Undertaking in Respect of Third level Academic fees

Please retain copy in candidate's file

Applicant's Declaration/Undertaking in respect of Third level Academic fees for Nurse and Midwife Medicinal Product Prescribing Programme

I understand that proposed leave entitlements will be subject to staffing demands at the time. I further agree that the entirety of the course fees paid by the HSE on my behalf will immediately become due and owing by me to the HSE if I:

a) Do not complete the Course successfully within the time frame designated by the relevant Higher Education Institution

b) Cease employment with the Health Service Executive before I have successfully completed the Course

c) Cease employment with the Health Service Executive at any time following successful completion of the programme within the period of twelve months or for the length of the academic course undertaken**.**

I agree to repay the amount of fees paid for me in respect of this course and salary on a pro rata basis for full time programmes.

Signed: _____ Date: _____

Director of Nursing/Midwifery/ Public Health Nursing Approval and Sign-Off

Signed: _____ Date: _____

Director of Nursing/Midwifery/Public Health Nursing Comments (optional)